**Medical and Dental Annual Registration/License Renewal Form**

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Please include a photo not more than a month old

**For renewal of Registration and Practice License.** Additional details should be added on separate paper and sent via email. Forms to are to be dropped to the Secretariat Office or posted at P. O. Box 18914, Suva.

All sections are compulsory. Use N/A if a Section is Not Applicable. **INCOMPLETE FORMS WILL NOT BE PROCESSED**.

***NOTE: You are to inform the Secretariat within 30 days whenever there is any change in the information provided in this form.***

**Year of Annual Renewal of License / Registration:** Click or tap here to enter text.

**Do you wish to practise? YES  NO**

**If “YES” – INDEMNITY INSURANCE will be required for ANNUAL PRACTICE LICENSE. Refer to Sec 10 of Form**

**If “NO” – INDEMNITY INSURANCE is not required and Registration can be maintained.**

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| 1. **PERSONAL INFORMATION** | | | | | |
| Surname: Click or tap here to enter text.  Forenames: Click or tap here to enter text.  Other Names: Click or tap here to enter text. | | | | Tax Identification Number: Click or tap here to enter text.  Registration Number: Click or tap here to enter text. | |
| Residential Address: Click or tap here to enter text. | | | | Postal Address: Click or tap here to enter text. | |
| Telephone: Click or tap here to enter text.  Work: Click or tap here to enter text.  Mobile: Click or tap here to enter text. Email: Click or tap here to enter text. | | | | | |
| Next of Kin: Click or tap here to enter text. Relationship: Click or tap here to enter text.  Address: Click or tap here to enter text.  Phone: Click or tap here to enter text. Email: Click or tap here to enter text. | | | | | |
| 1. **EMPLOYMENT & PLACE[S] OF PRACTISE (Current Year)** | | | | | |
| Employer’s/ Practice Name[s]:  Click or tap here to enter text.  Government / Public  Private  Your Position[s]: Click or tap here to enter text.  Address/ Place[s] of Practice: Click or tap here to enter text.  Years of Service: Click or tap here to enter text. EDP # (*if applicable*): Click or tap here to enter text. | | | | | |
| 1. **RENEWAL IN** | | | | | |
| Category[s] of Registration / Licence sought:  **Medical Practitioner:**  General Registration  Vocational Registration in the field of: Click or tap here to enter text.  **Dental Practitioner:**  Dentist  Dental Therapist  Dental Hygienist  Dental Technician | | | | | |
| 1. **SUMMARY OF PRACTISE IN PREVIOUS YEARS (Please ensure that any gaps in the year of practice is explained with evidence)** | | | | | |
| **Dates** | | **Location** | | | **Position & Scope of Practice** |
| Click or tap here to enter text. | | Click or tap here to enter text. | | | Click or tap here to enter text. |
| Click or tap here to enter text. | | Click or tap here to enter text. | | | Click or tap here to enter text. |
| Click or tap here to enter text. | | Click or tap here to enter text. | | | Click or tap here to enter text. |
| 1. **OTHER QUALIFICATIONS GAINED DURING THE YEAR (Documentary Evidence is required to Update the Medical and Dental Practitioner Register:** | | | | | |
| Click or tap here to enter text.  Language of Instruction of course: Click or tap here to enter text. | | | | | |
| 1. **DISCIPLINARY ENQUIRIES & CHARGES (Concluded & Pending)** | | | | | | |
| **Date** | **Country** | | **Details & Outcome** | | | |
| Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. | | | |
| Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. | | | |
| 1. **MEDICAL FITNESS TO PRACTISE** | | | | | | |

Have you previously suffered or currently suffer from an injury or illness or condition(s) which may place you or your patients at an increased risk or harm? Yes  No

If YES, please detail conditions (include date of injury/illness/medication taken)

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| Click or tap here to enter text. |

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| 1. **CONTINUING PROFESSIONAL DEVELOPMENT –** List all CPD activities in the last 12 months. Use separate page if required providing documentary evidence   ***(Minimum: 25 hours for Medical Practitioners and 10 hours for Dental Practitioners per annum)*** | | | |
| **Date** | **Activity** | **Hours** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| 1. **PROFESSIONAL INDEMNITY** | | | | |

Do you have Professional Indemnity Insurance? Yes  No

Please provide the details and evidence. ***NOTE: It is UNLAWFUL to practise without Professional Indemnity (Insurance)***

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| Click or tap here to enter text. | |
| 1. **CRIMINAL/ OTHER CONVICTIONS** |

Are you facing any criminal, drug or alcohol related charges? Yes  No

If YES, please provide details:

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| Click or tap here to enter text. | |
| 1. **DECLARE INTEREST IN RELEVANT BUSINESS** |
| Section 93 of the Medical & Dental Practitioner Act 2010 requires a registered person or close relative to declare interest in a relevant business. Please provide details:  Click or tap here to enter text. |
| 1. **DECLARATION BY APPLICANT (Should be signed & dated for application to be considered complete)** |

* I undertake to display my Annual Practice Certificate in the Public area of my Practice;
* I undertake to comply with all relevant legislation and Council guidelines, regulations, codes & standards;
* I undertake to provide the Council/Secretariat police clearance reports from all jurisdictions should the Council seek such documents;
* I undertake to provide the Council/Secretariat Dental reports or any report pertaining to the practice should the Council seek such documents;
* I undertake to inform the Council within 30 days should any of the details at any time change than that be stated on this form;
* I undertake to cooperate with the Council/Secretariat in all matters pertaining to complaints and disciplinary proceedings;
* I consent to the Secretariat to divulge relevant practice details as per the Medical & Dental Practitioner Act 2010;
* I declare that I am fit for practise in the vocation I am applying for;
* I make this declaration in the knowledge that a false statement may amount to perjury and revoke my Practising Certificate;
* I solemnly declare to the best of my knowledge that all information provided is true and correct;
* I undertake to uphold the Medical / Dental profession in the highest esteem.

Signed: …………………………………………………………. Date: Click or tap to enter a date.

**PLACING YOUR NAME BELOW CONSTITUTES YOUR ELECTRONIC SIGNATURE.**

Name: Click or tap here to enter text. Place: Click or tap here to enter text.

**WARNING: False / Fraudulent Claims:**  In the event of any applicant submitting false or incomplete data, and or copies of certificates, which are found to be false, The Dental Registration authority of the applicant will be notified. The application for registration in Fiji will be unsuccessful; or provisional registration, if already given, will not be confirmed, and may be cancelled. Council/Secretariat may require further information before a decision is made.

**Supporting Documents Required:**

Please submit copies of the following documents with this application:

1. Certified copy of any new qualification gained;
2. Certificate of ‘good standing’ from the Medical/Dental Registration authority **IF** you practised outside of Fiji in the previous year;
3. Evidence of Professional Indemnity;
4. Completed documentation of Continuing Professional Development **(‘CPD’)** signed by Department Supervisor or Certificates Attained.

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| 1. **PAYMENT** |

A fee schedule is provided below and can be viewed on our website. Please make any cheques payable to the Secretariat of the Fiji Medical & Dental Councils. Should you wish to make direct payment, **add your details in the payer section (Practitioners Registration Number & Name)** & deposit the fee in our **ANZ Account # 10737532**. ANZ Swift Code: ANZBFJFX. Evidence of payment must be emailed to [**accountant@fijimds.com**](mailto:accountant@fijimds.com) ***and* attached with the application form.**

**Preferred method of payment**

Transfer Credit on our ANZ **Account # 10737532**  EFTPOS **(at Secretariat-Charges may apply)**  **CHEQUE**

***NOTE: For an application form to be complete, the applicable fee for the registration/license must be paid and attached with this annual renewal form.***

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| 1. **FEE SCHEDULE** |

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| **DESCRIPTION** | **RATE (FJD)** |
| Application fee Registration – resident | 20 |
| Application fee Registration – non-resident | 100 |
| Medical / Dental Practitioners in Government Services (Practice License Fee) | 200 |
| Medical / Dental Practitioners in Private Practice (Practice License Fee) | 200 |
| Vocational Registration – Medical / Dental Practitioners (Practice License Fee) | 300 |
| Dental Therapist/ Dental Hygienist/ Dental Technician (Practice License Fee) | 50 |

***If you only intend to REGISTER & NOT PRACTISE, only registration fee applies***

***If you intend to PRACTISE only PRACTICE LICENSE fee applies***

***NOTE:*  A penalty fee will be incurred for late submission of form and registration fee.**

**Definitions**

**RELEVANT BUSINESS** [in relation to Section 11 of the MDP Act 2010] – healthcare or other business in relation to the diagnosis, treatment, therapeutic services, prevention of disease, illness, injury, and other physical and mental impairments in humans. Practice in medicine, chiropractic, dentistry, nursing, pharmacy, allied health, and other care providers. It refers to the work done in providing primary care, secondary care and tertiary care, as well as in public health in private, public and voluntary organizations. It also includes medical equipment and pharmaceutical manufacturers, health insurance firms and educational instit